# Article

# The Oregon Death With Dignity Act: Implementation Issues

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**Passage of the Oregon Death With Dignity Act in 1994 raises nationally relevant questions for health care organization, state agencies, and clinicians. As debate over physician-assisted suicide continues in the United States, the experiences in Oregon may offer insight into the clinical complexities of legalizing physician-assisted suicide.**

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The Oregon Death With Dignity Act, a ballot initiative, was approved in the 1994 general election by a narrow margin—51% of voters in favor and 49% opposed. Since then, even though the legal status of the act is still undecided,* health professionals in Oregon have been pondering the concrete aspects of implementing it. The act specifies the parameters within which physician-assisted suicide would be permitted but does not spell out the policies necessary for its implementation.

The Death With Dignity Act would allow an attending physician, the doctor who is primarily responsible for managing a patient's terminal illness, to prescribe a lethal dose of medication for a terminally ill patient who requests it with the intention of self-administering it.[1] The act contains several safeguards. The patient must be an Oregon resident who is expected to live less than six months; he or she must be competent to make the decision; the act must be voluntary; and the request must be durable (the patient is required make two requests separated by a 15-day waiting period and one request in writing). The attending physician must obtain a second opinion to confirm that the diagnosis and prognosis are accurate and that the patient is competent and acting voluntarily. If the physician suspects that a psychological disorder such as depression is impairing the patient's judgment, referral to a mental health professional is also required. The attending physician must ask the patient to notify the family, but the patient is not required to do so. Compliance with the act is to be documented in the patient's medical record and reported to the Oregon Health Division. A physician has the right to refuse to provide the prescription even if the patient qualifies under the act.

Many observers interpreted the electorate's approval of the act as a strong indictment against the current standard of care for terminally ill patients. As a result, resources have been directed toward improving end-of-life care in Oregon.[2,3] Effort has also been directed toward developing policies, procedures, and clinical practice guidelines related to implementing the act. In the process, it has become apparent that the voters' approval was but the first step, presenting new issues for health care systems, state agencies, and clinicians.

## Health Care Systems

If the law is enacted, health care systems face a basic issue: whether to allow physician-assisted suicide within the system. Several Oregon systems—organizations managed by Catholic religious communities, for example—will not. All health care organizations, including those that disallow the practice, need to develop policies and procedures for responding to patient requests for assisted suicide.

Organizations that allow physician-assisted suicide face other questions. Should patients take the medications while in the hospital? Should the practice be limited? For example, should physicians-in-training be excluded from eligibility to write prescriptions for assisted suicide? What should qualify a physician to render the required second opinion—experience in palliative care or in managing the patient's terminal illness? How should institutions guarantee physicians' ability to evaluate patients and prescribe medications for this purpose?

*The measure was to have been implemented thirty days after its approval, but it was blocked by an injunction as a result of a lawsuit filed in federal court. In August 1995, a federal District Court judge ruled that the law was unconstitutional, because it did not extend equal protection against suicide to terminally-ill patients. The Ninth US Circuit Court of Appeals reversed the lower court decision in 1997. The circuit court is currently considering a request for a review of its decision by the full Ninth Circuit. In another arena, both houses of the Oregon legislature approved bills in their 1997 session requiring the act to be returned to voters.

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Health care systems also face liability concerns and issues specific to pharmacology and emergency treatment. In a survey taken just after the election, 78% of Oregon pharmacists said that they would want to know if a prescription they were filling was intended for assisted suicide.[4] Must the physician state the purpose of the prescription? Should a pharmacist have the right to refuse to fill the prescription? If so, what procedures must be in place to allow for another pharmacist to fill it?

Because the act is not specific about the involvement of professionals other than physicians, it is not clear whether a pharmacist who knowingly fills a prescription for assisted suicide is potentially liable. Since pharmacists often release prescriptions to someone other than the patient and routinely counsel patients when they pick up prescriptions, what measures should be taken to ensure privacy and effective communication when a pharmacist is dispensing a prescription for physician-assisted suicide?

How should emergency departments and emergency medical technicians deal with physician-assisted suicide? An unprepared family member is likely to call 911 if he or she discovers that a loved one has ingested a lethal dose of medication prescribed for self-administration. Should there be policies for emergency departments and paramedics in the field to govern the withholding of resuscitation under these circumstances? A recent survey of Oregon emergency doctors found that 58% had already had to face this question in managing overdoses in terminally ill patients.[5] What kind of documentation of the patient's wishes and of compliance with the act should be required before resuscitation can be withheld? How will such information be made available to emergency departments and paramedics? If a staff member is morally opposed to withholding resuscitation from a patient who has intentionally overdosed in compliance with the act, what procedures must be in place to guide swift conflict resolution?

## State Agencies

Agencies responsible for implementing and regulating the act must resolve several questions. What procedures should be in place for handling suspected cases of abuse or noncompliance? The act specifies that the Oregon Health Division is to keep records. How should reporting be done? Death certificates can be obtained by family members in order to settle an estate. If the reporting is done using the death certificate, what measures must be in place to protect confidentiality for patients who do not want family members to know about the assisted suicide? How should the physician record the immediate cause of death on the death certificate in cases of physician-assisted suicide? Attributing death to the underlying disease is not strictly accurate.[6]

There are also challenges in interpreting the law. For example, the patient must be an Oregon resident, but the act does not define residency. The exact meaning of "self-administration" is also vague—does it refer only to oral ingestion, or does it encompass intravenous or nasogastric administration by the patient? Home and home hospice nurses will need guidelines in this regard.

## Clinicians

*Professional codes and medical organizations.* Many professional codes dating back to the Hippocratic oath reject physician-assisted suicide. Currently, the American Medical Association, the American Nurses Association, the American Geriatrics Society, the National Hospice Organization, and the American Cancer Society all have position statements against legalization of physician-assisted suicide and participation by clinicians.[7-11] If the law changes to allow physician-assisted suicide, will these organizations modify their existing codes so as to provide guidance in this uncharted territory? How will clinicians make a decision about doing something that is legal but prohibited by professional codes?

During the election, the Oregon Medical Association and the Oregon Nurses Association found themselves caught between their parent organizations and the local environment. The Oregon Medical Association initially responded by remaining neutral during the election campaign because they perceived their membership to be divided on the issue. This perception was confirmed shortly after the election by our survey of Oregon physicians, which showed that 60% favored legalization of physician-assisted suicide.[12] Nevertheless, in 1997, the Oregon Medical Association House of Delegates approved a resolution opposing the Death With Dignity Act. The Oregon Nurses Association, in contrast, issued new guidelines after the act was approved that emphasized a nurse's choice regarding participation and provided practice guidelines for nurses in either case.[13]

*Clinician's right to refuse.* At present, a physician must decline to fulfill a patient's request for physician-assisted suicide because it is illegal. If it were legal, the physician would have to come to terms with his or her personal stance. Our survey found that 46% of doctors might participate in some cases if physician-assisted suicide is legal but that 31% were morally opposed and would never participate.[12]

For physicians who will not participate, where will they draw the line? Will they discuss it in depth with the patient and try to learn the reasons behind the request?[14] Will they evaluate the sources of suffering and intensify efforts to relieve them? In a recent report on assisted suicide, the American Medical Association stated that a patient's request should trigger such an evaluation.[15] The American College of Physicians Ethics Manual states that the physician who is opposed to abortion or contraception must make sure the patient gets information about all of the options from a qualified colleague.[16] What will be the guideline for physicians who morally object to participation in physician-assisted suicide?

An issue that has not received much attention is how to protect health care professionals' rights to conscientious practice. The act specifies that physicians have no obligation to participate but does not address the poten-

tial involvement of other professional members of the health care team. Nurses, pharmacists, social workers, clergy, and others may be involved in a patient's care. What kinds of policies are needed to protect patient confidentiality and provide continuity of care, yet allow freedom of conscience?

*Reimbursement.* As the act is written, at least two office visits to the attending physician are required, a second opinion, and possibly a mental health referral. Legislation has been passed that would prohibit the use of federal funds to pay for physician-assisted suicide. How will the clinician's time to evaluate patients who request physician-assisted suicide be protected and reimbursed?

*Appropriate decision-making and patient care.* Doctors have not been trained to talk about physician-assisted suicide, much less to evaluate patients who request it. How can we model dialogues that get to the underlying issues and unmet needs of the patient?[14,15,17,18] Physicians are used to going through certain steps to evaluate patients with various complaints. What steps are appropriate here? The act requires a six-month prognosis. When we asked Oregon doctors how confident they were about predicting that a patient has less than six months to live, 50% said they were not at all confident they could make such a prediction.[12]

Doctors are used to prescribing medication based on the results of clinical research and drug testing. Half of the doctors who responded to our survey said they were not sure what to prescribe for physician-assisted suicide[12]—those sources of information are simply lacking. There is descriptive information available from the Netherlands, from advocacy groups, and from American doctors who have had experience with assisted suicide,[19–21] but there is no information from the sources doctors are most accustomed to consulting.

Doctors will need to help patients and their loved ones to plan for the unexpected and for complications.[22,23] Who will be present when the patient takes the medicine? Will the doctor be present or available by phone in case complications develop? Doctors also will need to consider which other members of the health care team need to know of a patient's assisted suicide plan. A home health nurse may need to be made aware of the plan to prevent unwanted interventions and to allow the nurse a choice whether to remain involved in the patient's care or to transfer care to a colleague.

*Mental health.* The act requires the attending physician to refer the patient to a mental health professional if the physician suspects that depression or another psychological disorder is impairing the patient's judgment. In our survey, 28% of doctors who would be eligible to prescribe as attending physicians under the act said they weren't confident that they could recognize depression in a patient who requests physician-assisted suicide.[12] In fact, research has shown that primary care doctors do not detect depression about half the time.[24,25]

Will the mental health professional offer to evaluate patients as described in the act? If so, what should the evaluation comprise? The act suggests that the mental health professional should identify pathology that might be impairing judgment, confirm competency, and offer treatment if indicated. Is this role too narrow? The mental health professional has skills that might relieve suffering by teasing out the underlying issues, providing support, and developing a therapeutic relationship.[14,25]

The mental health professional's attitude toward physician-assisted suicide may bias the evaluation. A survey of Oregon psychiatrists done just after the election found that the majority of psychiatrists who are opposed to legalizing assisted suicide would refuse to perform an evaluation for a patient contemplating physician-assisted suicide, while most psychiatrists who support legalization would agree to do it.[26]

## Conclusions

Although it isn't clear whether the Oregon Death With Dignity Act will ever be implemented, its approval has had a major impact in Oregon. The care of dying patients has received attention and new practical issues for health care organizations, state agencies, and clinicians have become visible. These insights from Oregon about the concrete policy implications of such a change in current law have the potential to inform the ongoing debate about legalizing physician-assisted suicide in other parts of the United States.

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## A Father Explains DNA to his Son

*Double's* an easy word
the young child knew:
two, the same.
But what,
he asked
is a *helix.*

A shape so simple,
the scientist repeated,
once we know
the answer:

a spiral swirl,
an elegant pair
of chains, attracted
electrostatically.
The map of our future, son.
coils around a cylinder
of empty space

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